Teddie Joe Snodgrass, Inc.
DBA: Snodgrass' Pain & Family Clinic

SNODGRASS' CHRONIC PAIN MEDICATION MANAGEMENT AGREEMENT

Before starting on Opioid or Narcotic medication, you must agree to the following Snodgrass' Pain Management rules. Safety with these medications depends on your partnership with your provider and your pharmacy of choice.

1. **I have read and signed Snodgrass' Fact Sheet "Opioid Medication for Chronic Pain"**. I have had the chance to ask questions about anything I don't understand.

2. **I agree to have ONE provider prescribe my pain medications for me**. When they are gone or busy, they will identify someone else to prescribe medication in their place. I will tell any other health providers I see that I have a prescribing provider for pain medications.

3. **If I am in an emergency situation** and get pain medications, I will only accept **3 days or less of opioid pain medication. I will** immediately tell my prescribing provider about my situation.

4. **I agree to use ONE pharmacy** for pain medication. That pharmacy is ___________________________.

5. **The pharmacy or my provider may check the State Controlled Substance Databases** at any time. They will check to see if I am getting my pain medication at the pharmacy listed in #4. If I am getting pain medications at another pharmacy, my provider may wean me off and stop prescribing them for me.

6. **I will give my prescribing provider and the pharmacy 2 full working days** to refill my medication. I will not call on Friday afternoon, at night, or on weekends for refills. I will not ask for changes to my prescription afterhours.

7. **I will take my pain medications exactly as prescribed**. I will follow the directions exactly for the dose (amount to take) and frequency (how often I can take it). I will not crush, chew or otherwise change the medication.

8. **My provider will decide on any change in the strength (dose) or frequency** of my medication. Before taking a higher dose of my medication I will get the ok of my provider by phone or in-person.

9. **I promise to keep all of my pain management appointments**. This includes appointments to other specialties like counseling and physical therapy if recommended by my provider.

10. **I will not drink alcohol or use illegal drugs** including Marijuana while taking my pain medication.

11. **I will not drive or operate heavy machinery in the first 7 days** after starting or increasing my opioid pain medication. I will not drive or place the public at risk if I feel tired, foggy or unsteady. I realize that I can be arrested for driving under the influence of these medications.

12. **I am responsible for my medication.** If my medication is stolen or lost, it will not be replaced. When travelling, I will only take enough medication for the trip. I will store my remaining medication in a locked and safe place at home.

13. **I will store my medications properly**. I understand the best way is to store them in a locked container. This will protect small children and others who might take them.

14. **I will not sell, trade, share or give my medication away**. I understand that doing this is illegal. I understand that I can be arrested. I understand that if I do this my provider will stop prescribing those medications.

15. **I will tell my provider about ALL of the medications I am taking**.

16. **I agree to provide blood and urine testing and pill counts at any time** when asked.

17. **I give permission for my provider to talk with other healthcare providers** (doctors, clinics, hospitals, et cetra.), insurance companies, and any other sources that may have information about my medications and medication history or use.

18. **If I do not follow any part of this agreement, my narcotic, opioid or controlled substance medications may stop being prescribed for me**. If I have been dishonest my provider may stop treatment and stop prescribing medications for my pain.

19. **If my provider is worried that I am getting addicted**, I may be referred to addiction services. I agree to cooperate with any and all referrals.

20. **I recognize that this agreement** does not bind my provider or my pharmacy to treat or provide medications for me. My provider will use scientific data and clinical experience to guide treatment decisions for my care. My provider may consult a Pain Management Team to help manage my pain.

My signature means that I have had a chance to ask questions about this agreement. It means that I understand and agree with all of the statements above. A copy will be kept for future reference.

____________________________	__________________________	_________
Patient Printed Name	Patient Signature	Date
____________________________	__________________________	_________
Witness Printed Name	Witness Signature	Date